

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155813		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 02/17/2016	
NAME OF PROVIDER OR SUPPLIER VILLAGES AT HISTORIC SILVERCREST THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1809 OLD VINCENNES ROAD NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/31/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/17/16</p> <p>Facility Number: 012619 Provider Number: 155813 AIM Number: 201238590</p> <p>At this PSR survey, The Villages at Historic Silvercrest was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This five story facility with a basement was determined to be of Type II (222) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 54 and had a census of 50 in the healthcare portion of the facility at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review on 02/18/16 by Lex Brashear, LSC Specialist</p>			{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155813	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 02/17/2016
NAME OF PROVIDER OR SUPPLIER VILLAGES AT HISTORIC SILVERCREST THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1809 OLD VINCENNES ROAD NEW ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	